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Legal Protection for Health Insurance Policyholders Against Claim Denials Due to Non-Transparent Information in Insurance Policies

Erich Stepanes*, Christin Septina Basani
Universitas Kristen Maranatha, Indonesia
Email: Kims.rich11@gmail.com*, christinseptina@yahoo.co.id

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ABSTRACT
Health is a necessity for everyone, regardless of socioeconomic status, and health insurance is essential to ensure access to quality medical services while mitigating the financial impact of accidents and illnesses. In Indonesia, a common issue with insurance is the lack of customer understanding of policy terms, leading to misunderstandings. Legal Protection for Health Insurance Policyholders Against Claim Denials Due to Non-Transparent Information in Insurance Policies includes several measures. Customers should actively ask agents and insurance companies for clear explanations of policy terms, carefully review the policy before signing, and contact the Financial Services Authority (OJK) or the Consumer Dispute Settlement Board (BPSK) for mediation. If these steps fail, customers can resort to civil lawsuits. Legal remedies for failed claims involve understanding one's rights, gathering relevant evidence, seeking written clarification from the insurance company about the claim rejection, and filing an official complaint to OJK. If the issue remains unresolved, the customer can pursue legal action in court.

INTRODUCTION

Health is an important thing that must be paid attention to and pursued by everyone, health is very important to support the sustainability of daily activities productively (Novita et al., 2022). Health regardless of socioeconomic status is a need for everyone. Globally, health insurance disputes have become a significant concern in consumer protection. According to the Organisation for Economic Co-operation and Development (OECD), transparency in financial services, particularly insurance, is a critical pillar of consumer protection frameworks across member countries. The International Association of Insurance Supervisors (IAIS) emphasizes that inadequate disclosure of policy terms is among the top causes of consumer complaints worldwide, affecting millions of policyholders annually. In developing economies, the World Bank reports that information asymmetry between insurers and consumers remains a persistent barrier to financial inclusion and effective risk management.

In the Indonesian context, the issue of non-transparency of health insurance policy information has become an important issue that affects public trust in the insurance industry. Data from the Financial Services Authority (OJK) shows that complaints related to the rejection of insurance claims have continued to increase in recent years, with most cases rooted in customers' lack of understanding of the terms of the policy. This not only harms consumers financially, but also erodes public trust in insurance-based health protection systems. Illness

and accidents are things that cannot be ignored and human life is related to various activities that must be managed by each individual. However, every activity that is carried out of course there is an opportunity for an event to occur that can be experienced by anyone without realizing it and it is called a risk and we cannot avoid or refus (Rahman, 2024).

Health is the desire of everyone who must continue to be maintained in order to be able to work and do activities properly, it is good for every citizen to have health insurance considering that it can reduce financial risks. With health insurance, we have the advantage of having access to quality medical services and protecting insurance customers from unfavorable financial impacts from accidents and illnesses. In addition, peace of mind can also be felt if you have health insurance. The definition of insurance according to law No. 40 of 2014 Article 1 paragraph 1 concerning Insurance "insurance is a written agreement between two parties, namely the insured party (customer) and the insurer (insurance company)". The customer pays the premium to the insurance company, and the insurance company promises to provide compensation or benefits to the customer if something happens to the customer or his belongings in accordance with the agreement of both parties. In the research of Putra J.A.D., Sjaaf A.C. (2022) on Comparison of the Health Service System and the Universal Health Insurance among Indonesia's Neighboring Countries, Health is a basic right and need for everyone and has been mandated in Law No. 36 of 2009 Article 5 paragraphs 1 and 2 concerning Health "that every citizen has the right to have access to the same health services, equal, fair, safe, quality and affordable". Insurance has the benefit of providing protection against risks or losses that can occur in the future (Zainal, 2020). The purpose of having health insurance is to avoid excessive financial losses in the event of illness and to be able to get appropriate care when sick. The insurance company will cover the expenses at the hospital as agreed (Anisa Darania et al., 2023).

Everyone generally anticipates risks in various ways, one of which is by having an insurance policy by buying, based on their own insights, which can be sourced from their own understanding or from other sources (Fazri & Kurniawan, 2021). Insurance is a form of risk management that is applied by transferring risk from the customer to the insurance company. According to Article 246 of the Commercial Code, "Insurance or coverage is an agreement, in which the insurer binds himself to the insured by obtaining a premium, to provide him with compensation for a loss, damage, or not getting the expected profit, which may be suffered due to an uncertain event". From this Article, it can be understood that in the insurance agreement there are two parties, the insurance company as the insurer and the customer as the insured who are bound by an agreement for the transfer of risk for an uncertain event with the payment of benefits if the uncertain event occurs with the payment of premiums by the insured to the insurer.

Through the mechanism of transferring risks from customers to insurance companies, insurance can provide a sense of security and protection against financial losses. In addition, insurance also plays a role in improving the efficiency of risk management, encouraging economic growth, and mobilizing public funds through the accumulation of collected premiums.

This research is urgently needed for several fundamental reasons. Data from the Financial Services Authority (OJK) as of June 2021 shows that 40% of the total 2,600 insurance-related

complaints are about policyholders' difficulties in claiming settlements, indicating that claim denials are a systemic issue requiring serious attention. Furthermore, while consumer legal awareness has risen in recent years, it is not matched by an adequate understanding of their rights within insurance contracts, a gap that creates vulnerability to exploitation by unethical business practices. Despite existing regulations like the Insurance Law and Consumer Protection Law, their implementation and effectiveness in shielding consumers from non-transparent information practices require evaluation, as sanctions for informational violations remain weak and difficult to enforce. Additionally, industry digitalization has introduced new complexities in policy communication, where consumers often receive lengthy, complex digital documents without proper explanation, heightening the risks of mis-selling and misunderstanding.

In health insurance there are two products, namely health insurance and health plus life insurance which have different protection purposes, health insurance for health protection only while health insurance plus life for health protection and financial compensation for the family if the insured dies, insurance coverage is an important instrument in modern financial techniques that provides financial protection for everyone and also family against possible illness, death or disability. In its application, insurance is a form of long-term agreement that requires trust between customers and insurance companies. Therefore, a good insight into the rights of customers and the protection related to this product is essential (Febrianti & Zainarti, 2025).

The novelty of this research lies in several distinct contributions. It specifically analyzes non-transparent information as the primary cause of claim failures, rather than treating it as a general consumer protection issue, thus providing a sharper focus on the root problem. It also offers an in-depth analysis of standard clauses in health insurance policies from the perspective of Indonesia's Consumer Protection Law, particularly regarding prohibitions on unfair terms, an area not thoroughly explored in previous studies. Moving beyond theoretical analysis, the research provides concrete, practical guidance for consumers in the form of systematic steps to take when facing a claim denial due to opaque information, covering preventive measures, mediation, and litigation. This is supported by the integration of juridical analysis with real case studies to give an applicable picture of how information opacity occurs and should be legally resolved. Finally, the study offers specific policy recommendations for strengthening the OJK's supervisory mechanisms over insurers' information obligations, providing valuable input for regulators to refine existing frameworks.

In the insurance sector, Indonesia has made considerable progress in recent years. Support from economic development, technological advancements, and risk awareness have driven the industry's growth to become one of the largest in the Southeast Asian region. In the midst of this dynamic, legal protection for insurance customers is a crucial issue that requires serious attention. The importance of legal protection for insurance customers should not be underestimated. Customers as parties who entrust their funds and risks to insurance companies, have the right to receive fair and equitable protection. This protection covers various aspects, from providing clear and open explanations of insurance products to fast and efficient claims settlement (Hutagalung, 2024). In the research of Rahmat Lukum et al (2025), "Analysis of Consumer Protection in the Insurance Claim Process Based on Law No. 8 of 1999 on Consumer

Protection", customers have the right to obtain clear information about the policy, compensation for losses, and dispute resolution.

The purpose of this research is to provide legal protection for customers of health insurance companies in Indonesia, avoid mistakes in understanding the language in insurance policies, and the importance of knowing detailed and transparent information. That way, a sense of justice can be realized for customers and insurance companies, so that the insurance industry can always grow constantly and for the Indonesian people can provide maximum benefits.

This research is a reflection of three previous studies, namely Suryati, Agustianto (2023) entitled "Legal Protection of Health Insurance Customers in Settlement of Insurance Policy Claims" which realizes that policyholders are usually individuals or individuals and many have weak financial conditions when dealing with insurance companies, so various laws and regulations provide owners with more vigilance and legal protection against the possibility or possibility of the insurance company's mistakes. Research by Zakaria Adjie Pangestu, Latifatul Islamiyah (2023) entitled "Legal Protection of Insurance Policyholders Based on the Indonesian Legal System" that legal protection in the insurance industry has basically been regulated in the Consumer Protection Law, which states that customers must get five principles consisting of security, comfort, justice, benefits, balance, safety, and legal certainty. U.S. Army Corps of Engineers et al. (2025) entitled "Legal Protection for Insurance Company Customers" that legal protection for insurance company customers in Indonesia faces complex challenges, including lack of customer awareness, regulatory effectiveness that needs to be improved, and adaptation to digitalization developments. This research aims to provide legal protection for health insurance customers who have defaulted due to claim rejection by ensuring that fairness in contractual relationships is protected as well as the rights of customers and the available settlement mechanisms if they do not get satisfactory answers.

A common issue in the insurance industry in Indonesia is that policyholders often do not fully understand the content of the insurance agreements they enter into, which leads to misunderstandings. Additionally, intense business competition encourages some business actors to use unethical practices to attract consumers, including providing non-transparent information. Based on this context, the problem formulation can be summarized as follows: First, what legal protections are available for health insurance customers who experience failed claims due to non-transparent information in their insurance policies? Second, what legal remedies are available for customers whose claims fail because of the submission of non-transparent health insurance policy information?

METHOD

The method used in this study is normative juridical, which focuses on principles or norms in positive law, which are based on legal rules or laws. The research approach is the Regulatory Approach (Juridical-Normative), namely Law Number 40 of 2014 concerning insurance and the Conceptual Approach (Theoretical), namely the Principle of Insurance., which aims to understand legal protection for health insurance customers, then examine its conformity with related laws and regulations so that problems and appropriate solutions can be found to overcome problems. The law that currently underlies insurance in Indonesia is Law Number 40 of 2014 concerning insurance, with the concept of risk sharing, where a number of participants

(insured) jointly pay contributions (premiums) to the insurer (insurance company), who will then bear the insured's health expenses when needed.

RESULTS AND DISCUSSIONS

Legal protection for health insurance customers for failed claims due to information in non-transparent insurance policies

Insurance or guarantee has been known in the world for a long time, it was first known in 1750 BC, in this year the codification of Hammurabi law was found, one of the provisions in the codification of Hammurabi's law is the obligation for sellers who buy goods using loans and moving them by ship to pay off a certain amount of money as a guarantee that the loan will not be valid if the ship is stolen. This provision is what initiated insurance, while in Indonesia it was first known during the Dutch rule in 1843 which is known with the establishment of the first insurance industry in Indonesia on January 8, 1843 in Kali Besar Timur, Jakarta which was formed by a Dutch citizen named Bataviaasche Zee en Brand-Assurantie Maatschappij.

According to Philipus M. Hadjon (2023), legal protection is the protection of dignity and dignity as well as the recognition of human rights as a subject of law, while according to Satjipto Rahardjo, legal protection is providing protection for human rights that are harmed by others and that protection is given to the community so that they can enjoy all the rights granted by the law.

In general, insurance can be interpreted as a form of protection against future uncertainty The purpose of having insurance is to protect against uncertainty that can result in financial losses (Hafizah & Lubis, 2023). By buying an insurance policy, insurance customers have a sense of security and peace of mind because financial losses can be minimized. The meaning of coverage or insurance contained in Article 246 of the Criminal Code, namely: "Insurance is an agreement by which the insurer binds itself to the insured by receiving a premium to replace him for expected losses, damages, or losses that he may suffer due to an event that does not necessarily occur."

In insurance, we know the following principles:

1. ***Insurable Interest***

   That is, insurance coverage by a person must have an interest in the insurable property.

2. ***Utmost Good Faith***

   Declare an action to be precise and comprehensive, to all material facts about something to be insured, whether requested or not.

3. ***Proximate caus*** **(Dominant Cause)**

   A dominant trigger that causes a loss in a series of events.

4. ***Indemnity***

   A method that requires the provision of financial compensation (compensation) by an insurance company in an effort to put the customer in a controlled financial position shortly before the loss (Criminal Code articles 252, 253 and emphasized in article 278).

5. ***Subrogation*** **(Transfer of Rights)**

   That is, transferring rights from the customer to the insurance company if the customer has paid off the compensation to the insurance company.

6. *Contribution* (Awards)

Ensuring an object to several insurance companies that the customer does, there will be what is called a premium in providing protection from the insurance company.

From the principle of insurance, there are rights and obligations that give promises to each other, between the insurance company and the customer. Customers and insurance companies have rights and obligations that have generally been contained in an insurance policy that has been agreed upon by both parties. In the principle of Utmost Good Faith , it is emphasized that all parties are obliged to be honest in providing information both from customers and insurance companies and must not take advantage of information imbalances to get around one party. Insurance customers have the right to obtain compensation and/or compensation, if the coverage obtained rejects the content of the agreement, as stipulated in Law Number 8 of 1999 concerning Consumer Protection.

The obligations of insurance companies to customers are designed in clear and firm laws and regulations. first, Law Number 40 of 2014 concerning insurance which determines the obligations of insurance companies very firmly, Second, the Commercial Law (KUHD) also provides a clear picture of insurance as an agreement, and third, Financial Services Authority Regulations.

In Article 1313 of the Civil Code, it is described that the relationship between an agreement and an agreement is that the agreement issues an agreement. In every engagement, it is born either by agreement or by law. In this case, it is stated that every civil obligation can be carried out because it is desired by the parties involved in the agreement formed by the parties intentionally, or because it is stipulated by the applicable laws and regulations (Kusumaningrum et al., 2025).

An insurance policy is a form of an agreement or agreement between the insurance company and its customers, it may occur when the agreement or insurance policy is signed, there is already a standard clause made for the customer as a policyholder in a weak position and there is a clause that is not commensurate (Indra, 2023). In a standard health insurance agreement, there are some things that are generally non-negotiable because of their nature that has been unilaterally determined by the insurance company such as policy and protection clauses (customers cannot change the list of exclusions or other protections), premiums and payments, claims terms and procedures, limitations on benefits paid by the insurance company, policy validity period, exclusion clauses to which the insurance company is not obligated pay claims and dispute resolution clauses. In Indonesia, the law that regulates standard clauses in a business agreement or business agreement, which is regulated in Article 18 of Law No. 8 of 1999 concerning Consumer Protection paragraph (2) which reads: "Business actors are prohibited from including standard clauses whose location or form is difficult to see or cannot be clearly read, or whose disclosure is difficult to understand". Then in paragraph (3) it is explained: "Every standard clause that has been stipulated by the business actor in a document or agreement that meets the provisions as referred to in paragraph (1) and paragraph (2) is declared null and void". The application of the provisions of paragraph (3) of the use of standard clauses as stipulated in paragraphs (1) and (2), is often found. Then in paragraph (3) it is also said "Business actors are obliged to adjust standard clauses that are contrary to this law".

Regarding the standard clause, the steps that can be taken to get justice in an agreement agreement is with coaching and supervision, where the responsibility to make supervision and guidance is carried out by the government as stipulated in Article 29 of Law No. 8 of 1999. Good faith in Article 1338 paragraph (3) of the Civil Code, says that agreements must be implemented in good faith. A well-intentioned person puts his trust entirely in the opponent who is seen as honest and does not hide something bad that may one day cause problems (Navisa, 2020).

Customer understanding of insurance products is very important so that there are no misunderstandings that can cause disputes in insurance claims, transparency in insurance policy information is also important for customers regarding what is offered, and what are the obligations of the customer and what are excluded from doing, because the explanation of insurance products is the responsibility of the insurance company and the insurance agent. Insurance companies must provide clear and accurate information regarding the products they offer. On the other hand, insurance agents also have the responsibility to explain the product in detail to potential customers, ensuring that they understand the rights and obligations contained in the insurance policy.

In an insurance policy, the element of need is a condition that must be present for the customer. If this requirement does not exist, then the risk is that the insurance policy can be void. Article 250 of the Criminal Code states: "if a person takes out insurance for himself or for the benefit of a third party, at the time of the insurance is held the insured or the third party concerned does not have an interest in the insured property, then the insurer is not obliged to compensate for losses".

An insurance agreement is a specially made agreement, the rules in the Criminal Code that are specifically contained but are not separated from the rules that are regulated in the conditions for the validity of the agreement based on the Civil Code written in Article 1320 of the Civil Code, but in an insurance agreement there are special conditions contained in Article 250 and Article 251 of the Commercial Code (KUHD). In an insurance policy, it usually contains the identity of the parties (customer and insurance company), Explanation of terms (such as insured, insurer, premium, claim), Details of benefits, Terms and conditions, Limitations and exclusions, Customer obligations, Claim procedure, Policy validity period, Premium and payment method and cancellation conditions, Hospital partnership.

In insurance, there are 6 (six) conditions for the validity of an insurance agreement:

1. **Agree**

The parties (customers and insurance companies) have previously reached an agreement in the insurance agreement.

2. **Proficiency**

Both parties, both customers and insurance companies, must be classified as capable or adult and have the authority to perform a legal act.

3. **Specific objects**

The objects contained in the insurance policy can be wealth, as well as the needs attached to the property or it can also be a person's soul or body.

4. Halal clauses

In relation to the halal clause, the formation and content of an agreement does not violate the rules or go against the provisions of the law, does not conflict with public order and morality.

5. Insurable interests

In this provision, the object of insurance is still related to the provisions in Article 250 of the Commercial Law Code (KUHD) which states that "if a person has taken out an insurance for himself, or if a person for whom an insurance has been held, at the time of the insured has no interest in the object insured, then the insurer is not obliged to provide compensation"

6. Notice

The customer is obliged to notify the insurance company regarding the subject or situation of the insurance object in accordance with the reality. If the customer does not carry out this or ignores it, then the legal consequence is that the insurance policy can be canceled. As recorded in Article 251 of the Commercial Law (KUHD) which says that "all false or incorrect notices, or concealment of circumstances known by the insured about the object of insurance result in the insurance being void". The obligation to notify also applies if there is an increase or change in the risk of the insurance object must be notified by the customer to the insurance company.

In Indonesia, the development of the insurance industry has increased significantly in recent years. The growing trust in insurance in society does not mean that there is no dissatisfaction that can arise from the public towards insurance companies. Dissatisfaction from the public regarding the complexity of submitting insurance claims, claims that are rejected from insurance companies while insurance premiums are always paid by customers are important data to be resolved. Quoted from investor.id, "The Financial Services Authority (OJK) noted that as of June 20, 2021, there were 40% of the total 2,600 insurance-related complaints related to the difficulty of policyholders disbursing claims". Therefore, in this study, matters related to legal protection for insurance policyholders in insurance agreements will be examined. This is carried out so that customers and insurance companies fully understand the rights and obligations of each party (Putra & Sjaaf, 2022).

Standard clauses made by insurance companies without involving consumers reflect that there is a principle of contractual fairness that is violated (Rambe & Sekaraya, 2022). An agreement is said to be fair when it is made jointly by both parties, without any pressure or pressure of will (Lukum et al., 2025). If the insurance policy is given in non-negotiable conditions, the customer's contractual rights are lost, so that the equality of meaning cannot be realized. Therefore, a regulatory system is needed that can consider the meaning and model of standard clauses so that the principle of justice in the alliance can be harmonized (Oscar et al., 2024).

One example of a lack of understanding of insurance policies is the rejection of insurance claims, cases of rejected claims have been experienced by insurance customers who use health insurance, namely PRUhospital Care products. PRUhospital Care is a health insurance product which provides benefits for the treatment of customers who are hospitalized, carry out the healing process in the emergency room, perform surgery or surgery and receive treatment at the hospital when the customer is hospitalized due to an accident while traveling abroad. The customer has an accident while travelin(Roesnia et al., 2025). The submission of a claim is made by one of the family members to the company, but the submission is rejected by

the company, the claim submission is rejected by the company because the customer is not on time or late in carrying out the obligation to pay the insurance policy (Sartika & Saleh, 2024). One of the staff, Mr. Angga, took care of the objections of PT. Prudential Life Assurance Binjai branch explained that the reason the claim was rejected was because the customer's insurance policy was in a lapse period (inactive) due to the impact of unpaid insurance premiums when they were due. This is an exception in the payment of customer claims, this exception is not informed in advance to the customer The solutions that can be delivered by PT. Prudential Life Assurance Binjai branch after the rejection of the claim against the customer that occurs is that the claim can be made but the customer must first make a payment or pay off the premium or insurance policy that has been due (Saragi et al., 2025). So that the submission of a claim for the policy can be done again if the premium payment has been paid off and has been received by the company (Sinaga, 2022). From these incidents, we can compare which is better between private health insurance and BPJS Kesehatan, both have their own advantages and disadvantages depending on the individual situation. BPJS Kesehatan is very beneficial for individuals who need health protection at an affordable cost and have access to basic services. Private Health Insurance is better suited for those who want flexibility, quick access, and broader health coverage, although they must be prepared for higher premium costs (Saputra et al., 2021).

Principle "take it or leave it" is often applied in standard contracts, including in insurance agreements. This principle refers to a situation in which the service provider (in this case the insurance company), offers an agreement with pre-determined terms and conditions, and the other party (the customer) does not have the discretion to negotiate or change the terms. If the customer does not agree to these terms, they have the option to reject the entire agreement. Therefore, it is very important to take protective steps that can be taken to avoid losses in the future, namely customers must be active in asking for explanations from insurance agents and insurance companies regarding the content of the policy, especially the exclusion article, reading and understanding the policy carefully before signing, contacting the OJK and BPSK for mediation and the last step of a civil lawsuit to the court.

Legal remedies for failed claims due to non-transparent submission of health insurance policy information

According to Article 31 paragraph 2 of Law No. 40 of 2014 "Insurance Agents, Insurance Brokers, Reinsurance Brokers, and Insurance Companies are obliged to provide true, non-false, and/or non-misleading information to Policyholders, Insureds, or Participants regarding the risks, benefits, liabilities and charges related to insurance products or Sharia insurance products offered". The law seeks to provide legal protection for customers by requiring agents and insurance companies to provide true and non-misleading information. However, even though there is this regulation, the role of the OJK as a supervisor is still needed, because there are still many customers who feel that the information they receive is not clear. It would be nice if the customer felt that they did not get enough information, they have the right to ask for clarity from the insurance company or their agent. Disputes regarding health insurance claims are caused by differences in understanding between customers and insurance companies regarding

the implementation of rights and obligations contained in the insurance contract or policy(Azzahra, 2024).

In Article 246 of the Commercial Law (KUHD), an insurance claim is a claim by the customer regarding the existence of an agreement contract between the customer and the insurance company, where both parties agree to provide a guarantee to pay compensation by the insurance company if the customer has made a premium payment for the disaster experienced by the customer. Insurance claims aim to provide benefits in accordance with the rules in the insurance policy to customers (Sugara, 2025).

Claims in insurance claims submitted or submitted by customers in connection with the existence of a contractual agreement with the Insurance company, the rights of the Policyholder are fulfilled as stated in the Policy. If the customer has paid the insurance premium, then when the customer experiences a risk, the insurance company is obliged to provide benefits to the customer in accordance with the agreement in the insurance policy (Soehaiya, 2022).

One of the causes of disputes that often occur is the lack of information obtained by insurance customers and the lack of explanation of insurance products from insurance companies. Disputes can also arise as a result of a delay or refusal to pay claim benefits by the insurance company, to the detriment of the policyholder or beneficiary. In situations like these, policyholders are generally in a disadvantaged situation compared to insurance companies, due to lack of knowledge of their rights or limited resources to pursue legal remedies. In this case, it is important to know who can be sued in the event of a problem related to minimal information. Customers can sue the insurance agent for providing incomplete explanations and the insurance company for being responsible for the policy and the information provided, depending on the context of the case. Therefore, adequate legal protection mechanisms are needed to protect the interests of policyholders and ensure fair and efficient dispute resolution.

Meanwhile, the problems that often occur in insurance companies are insurance products offered by insurance agents to customers with information that is not transparent. For example, the lure by the insurance agent will be a full premium refund if the claim submitted within a certain period of time does not exist, but, when submitting a claim for a refund of premiums, many customers feel aggrieved, it turns out that an explanation is not given in detail about the additional conditions at the time of product sales, as a result, customers who cannot get the promised premium refund are quite a lot (Suryati & Agustianto, 2023).

One of the things that needs to be considered is the lack of consumer access to transparent, complete, and easy-to-understand information about the insurance products they purchase. The explanation provided by the insurance company is inadequate about the risks, benefits, and conditions contained in the policy as a whole to prospective customers. Closed information expands the potential for misunderstanding, as a result of which the claim is rejected or the process of disbursing insurance benefits cannot be continued. Even though this ignorance is due to the lack of transparency and assistance from insurance companies (Yusrani et al., 2023).

Insurance claims are rejected because, if there is an unexpected event or disaster, insurance customers hope to receive their rights by submitting an insurance claim according to the insurance policy. However, to make this insurance claim, sometimes the insurance company

refuses. This for the insured is a great dissatisfaction if his insurance claim is rejected. There are several reasons why an insurance claim is rejected, including:

1. When the proposal and data are filled in by the customer, the customer makes a mistake when filling in the data and proposal for the submission of an insurance claim
2. Due to late payment of premiums on policies that have expired Insurance policies are inactive (lapse)
3. When purchasing an insurance policy, the customer is dishonest in disclosing a history of illness such as certain health conditions that were already had before the enactment of the protection of related benefits (pre-exixting condition)
4. The risks experienced by customers in insurance are not guaranteed
5. Has not entered the coverage period or when the coverage period has ended but the customer makes a Claim
6. Insurance companies get late information from customers
7. There has been a loss but the evidence cannot be shown by the customer.

The Consumer Protection Law (UUPK) is the legal basis for consumer protection in general. The consumer's right to comfort, security, and safety in accessing products as well as the right to correct and honest information are listed therein. In terms of insurance, policy transparency, clarity of benefits, and protection against misleading marketing practices are the rights listed in it.

Legal protection for customers is important to study as a health insurance policy owner, because in practice the use of standard clauses in health insurance agreements is often carried out by health insurance companies. This results in weak legal protection and the position of the customer when the insurance policy is signed by the customer. The customer's position is weak due to the standard clauses in the insurance policy which are related to premium payments, terms, conditions and dispute resolution that cannot be negotiated or negotiated with the insurance company. An imbalance in the position between the customer and the insurance company can cause losses for customers in making health insurance claims. When claiming by customers to insurance companies, convoluted procedures are sometimes experienced, and finally rejection is experienced by customers for a number of reasons. The customer as the policyholder is disadvantaged if he does not get the right to the benefits of the policy he purchased. The legal consequence of a failed insurance claim is that the customer can take legal steps through the court or out of court.

Protection for customers legally in the insurance industry is regulated, one of which is the Consumer Protection Law, where transparent, true, and non-misleading information about the products they buy is a right obtained by consumers. Insurance promises that contain fraudulent elements can be classified as acts of violation of consumer rights. In Article 8 of the Consumer Protection Law, there are several provisions "business actors are prohibited from producing and/or trading goods and/or services that: 1) Are not in accordance with the promises or descriptions stated in the advertisement. 2) Not in accordance with the provisions stipulated in the applicable law". Thus, insurance companies that provide improper promises of benefits can be considered to violate the rights of consumers and can be prosecuted.

Legal remedies for failed claims due to the submission of information in a non-transparent health insurance policy are important to protect the rights of customers, by perform several Steps, namely:

1. Customers must first know about their rights based on Law No. 8 of 1999 and Law No. 40 of 2014 that consumers have the right to clear and non-misleading information about the products they purchase.
2. Gather all relevant evidence, such as copies of the insurance policy and related documents, proof of communication with the insurance agent (emails, messages, conversation recordings), details of the claim submitted and proof of denial of claim from the company.
3. Contact the insurance company and ask for written clarification regarding the reason for the claim denial.
4. If they do not get a satisfactory response from the insurance company, customers can file a formal complaint with the Financial Services Authority (OJK) as the institution that supervises the activities of the insurance company and complaints from customers. The Consumer Dispute Resolution Agency (BPSK) which usually resolves disputes between consumers and service providers.
5. If all of the above efforts are unsuccessful, customers can consider taking legal action by suing the insurance company in court. In this case, the customer should: formally draft a claim, including a statement of claim and supporting evidence, show that the lack of transparency of the information negatively affects their decision to purchase the policy and on the claim filed, seek the help of legal counsel or a lawyer who specializes in the field of insurance to assist in this process.

CONCLUSION

Insurance serves as a protective mechanism against future financial risks through agreements between customers and companies, where standard clauses often place customers in a weaker position, though they can reject unfavorable terms; validity requires elements like necessity under Indonesia's Civil Code (Article 1320), and non-transparent information—such as unnotified policy exclusions for late payments—frequently leads to claim denials and disputes due to inadequate explanations of products. Customers can mitigate this by actively seeking clarifications from agents, thoroughly reviewing policies (especially exclusions), reporting to the Financial Services Authority (OJK) or Consumer Dispute Settlement Board (BPSK) for mediation, involving consumer protection agencies, or pursuing civil lawsuits, emphasizing the need for transparency to foster fair contractual relationships. For future research, scholars could investigate the effectiveness of digital tools, such as AI-driven policy summarizers or mandatory transparency dashboards mandated by OJK, in reducing claim denial disputes among health insurance policyholders in Indonesia through empirical studies comparing pre- and post-implementation data.

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